

"unnecessary surgery"

several points made by Drs. in their recent article on "unnecessary surgery" made clear that the unions' second-opinion program are not. Moreover, their members are middle class strata.

which are included in the ranks in the following areas: stores, teamsters (moving van maintenance, municipal services, majority of the last group being among the unions are reprehensible white collar workers. While the population could be considered as who would be classified as upper middle class. Indeed, the program is the best by the normal standards are represented. In particular, black, hispanic, and Chinese

operations are included in the spectrum of elective surgical subspecialties. Regarding consultant's recommendation, it is always up to the individual. The second-opinion study is a consumer-oriented program designed to measure the opinions of physicians.

The population reflects the ethnic diversity of the Greater New York Area. The Cornell study have been conducted in the area (by Blue Cross/Blue Cross second-opinion program), as well as Michigan's Blue Cross/Blue Cross and by Motorola's second-opinion program (Arizona)—to name only a few results.

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opinion surgical program. Similar programs have been instituted in many areas of our country, and it is important that their structure and function be understood in light of the controversy which surrounds them. As McCarthy and Finkel state, and as we emphasized in our article, the second-opinion programs were designed as consumer-oriented programs, with an "overall objective to screen those elective operations which otherwise might be deferred or prevented without jeopardizing the general health and well-being of the individual." Unfortunately, misunderstanding of this objective by both the lay press and the American public has led to data from these programs being utilized in attempts to quantitate the amount of "unnecessary surgery" performed in the United States. In addition, although not designed to specifically measure the difference of opinion between physicians, they do, in fact, provide an imprecise but definite indication of the reliability and reproducibility of clinical surgical decision making.

McCarthy and Finkel state, "All elective, nonemergency operations are included in the study." This in itself is one of the major shortcomings. As we previously noted, "... little distinction is made between elective operations and discretionary procedures. The latter frequently incorporate the desires of the patient into the decision-making process." The directors of the Cornell study do not feel that this differentiation is significant. However, those procedures which involve incorporation of the patient's wishes into the surgical decision-making process consistently demonstrate the highest nonconfirmation rates. These include hysterectomy (27.3%), vein stripping and ligation (23.4%), and knee surgery (20.8%). A need for classification of surgical opinions into those which did and did not incorporate patients' desires might be indicated if data from such programs are to be interpreted meaningfully.

Lastly, we stand by our statement, "... there are well known regional differences in short-stay hospital admissions, with the northeast United States having the highest percentage of patients hospitalized for surgical procedures." It is crucial that such health statistics be factored into the overall assessment of second-opinion programs when evaluating their cost-effectiveness from one section of the country to the next.

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Operative implications of preduodenal portal vein

To the Editors:

Makey and Bowen,³ in their recent article, "Preduodenal portal vein: Its surgical significance," warn of the

y and Ms. Finkel for their
phics of the Cornell second-



Fig. 1. Normal lateral chest (left) has distinctive retrocardiac shadow from normally located inferior vena cava (arrow). The lateral chest film in absent inferior vena cava (right) demonstrates an "empty" retrocardiac space. Venous blood returns to the heart via azygous and/or hemiazygous pathways which drain into the superior vena cava.

surgical risks of a preduodenal vein in operations about the portal triad. We would like to point out the wider surgical implications of this anomaly, that is, the rarity of preduodenal vein as an isolated malformation. The portal venous anomaly is often just one manifestation of a constellation of perihepatic vascular and intestinal malformations. Of major interest to the surgeon are the associated vascular anomalies of aberrant hepatic artery and absent inferior vena cava. In the former, the right hepatic artery originates from the superior mesenteric artery and runs posteriorly in the portal triad. Because of the unusual location, it may be subject to operative injury. An absent inferior vena cava results from a failure of union of the hepatic and subcardial veins. Venous blood from the lower body returns to the heart via the azygous and/or hemiazygous systems.

The technical problems posed by this triad of perihepatic vascular anomalies were described by us earlier in operations upon patients with biliary atresia.^{1,2} In such patients, the vascular malformations may be anticipated by characteristic findings on plain chest films (Fig. 1). At first it was thought that the composite vascular anomaly precluded orthotopic liver transplantation. Since those publications, however, a child with these malformations had a successful transplantation and has survived with her homograft for more than 4 years.

The composite vascular anomaly also assumes significance in operations not directly involving the liver. An absent inferior vena cava would present a major surgical obstacle in portacaval shunt operations or in vena caval ligation. Moreover, in one of our patients, division of the azygous vein during tracheoesophageal fistula repair effectively interrupted the total venous drainage of the lower half of the body and contributed to the infant's death. Discovery of a preduodenal vein at operation should

immediately alert the surgeon to the real possibility of other major vascular malformations in the surgical area.

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1. Lilly JR, Chandra RS: Surgical hazards of co-existing anomalies in biliary atresia. *Surg Gynecol Obstet* 139:19, 1974
2. Lilly JR, Starzl TE: Liver transplantation in children with biliary atresia and vascular anomalies. *J Pediatr Surg* 9:707, 1974
3. Makey DA, Bowen JC: Prediudodenal portal vein: Its surgical significance. *SURGERY* 84:689-90, 1978

More on preduodenal portal veins

To the Editors:

After reviewing the recent article by Makey and Bowen,¹ "Prediudodenal portal vein: Its surgical significance," we wish to commend them on pointing out the need for awareness of this anomaly in biliary tract surgery. As the authors explained, this is a rare anatomical variant, which usually is associated with other congenital anomalies. Therefore, it is more likely to be encountered in surgery on the pediatric age group. Wakayama² reported a case of preduodenal portal vein associated with congenital biliary atresia, intrahepatic interruption of the inferior vena cava with azygous continuation, incomplete annular pancreas, and accessory spleens in February, 1976. At that time he reported 55 cases of preduodenal portal vein in the

world literature.
biliary atresia.
We recently
hyperbilirubinemia
noted at birth.
biopsy were
obstruction
significant hepatomegaly.
He also had
bowel, and
Kasai procedure
incidental anomalies
was excellent
up during
definitive therapy
biliary cirrhosis
prognosis.
We wish to
significance
associated anomalies
operative intervention
atresia.

Reference

1. Makey DA, Bowen JC: Prediudodenal portal vein: Its surgical significance. *SURGERY* 84:689-90, 1978
2. Wakayama H: Prediudodenal portal vein associated with congenital biliary atresia. *J Pediatr Surg* 11:100, 1976

Reply

To the Editors:

Dr. Makey and Bowen's letters for the journal, pointing out the association of this anomaly with other congenital anomalies, did not come to our attention retrospectively. In the radiographic review of the files, perhaps a recent letter from Dr. Halvorsen¹ to the editor, reporting a case of preduodenal portal vein associated with congenital biliary atresia, intrahepatic interruption of the inferior vena cava with azygous continuation, incomplete annular pancreas, and accessory spleens in February, 1976. At that time he reported 55 cases of preduodenal portal vein in the